PRINTED: 09/24/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPL							
		345164	B. WING			1	C 22/2018
NAME OF PI	ROVIDER OR SUPPLIER	l			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	22/2010
				1	1341 PARADISE ROAD P O BOX 566		
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER			EDENTON, NC 27932		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
170					DEFICIENCY)		
F 622	Transfer and Dischar	ge Requirements	F	622			9/17/18
SS=D	CFR(s): 483.15(c)(1)(07 117 10
33-0	0.11(0). 100.10(0)(1)((-)()()()					
	§483.15(c) Transfer a	and discharge-					
	§483.15(c)(1) Facility						
	(i) The facility must pe	•					
	remain in the facility,						
	discharge the residen	t from the facility unless-					
	(A) The transfer or dis	scharge is necessary for the					
	resident's welfare and	d the resident's needs					
	cannot be met in the						
		scharge is appropriate					
		s health has improved					
	•	ident no longer needs the					
	services provided by						
	` '	viduals in the facility is					
	_	e clinical or behavioral					
	status of the resident;						
	otherwise be endange	viduals in the facility would					
		failed, after reasonable and					
	` '	pay for (or to have paid					
	1	edicaid) a stay at the facility.					
		if the resident does not					
		paperwork for third party					
	payment or after the t						
		I, denies the claim and the					
	resident refuses to pa	ay for his or her stay. For a					
		s eligible for Medicaid after					
	admission to a facility	, the facility may charge a					
	resident only allowable	le charges under Medicaid;					
	or						
	(F) The facility ceases						
	1	ot transfer or discharge the					
		peal is pending, pursuant to					
	§ 431.230 of this chap						
		ight to appeal a transfer or					
		the facility pursuant to §					
		chapter, unless the failure to					
	discharge or transfer	would endanger the health					
ADODATODY	DIDECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUE	DE		TITI F		(X6) DATE

09/05/2018 **Electronically Signed**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMP	(X3) DATE SURVEY COMPLETED			
		345164	B. WING _		08/3	22/2018
	ROVIDER OR SUPPLIER RIVER NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932	CODE	2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 622	Continued From pag		F	622		
	facility. The facility	dent or other individuals in the must document the danger er or discharge would pose.				
	resident under any of in paragraphs (c)(1) section, the facility or or discharge is documedical record and communicated to the institution or provide (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of pasection, the specific be met, facility attenneeds, and the serv facility to meet the needs, and the serv facility to meet the nii) The documentati (2)(i) of this section (A) The resident's plastic discharge is necess (A) or (B) of this section (B) A physician when ecessary under pathis section. (iii) Information provimust include a minimust include	Insfers or discharges a of the circumstances specified (i)(A) through (F) of this must ensure that the transfer imented in the resident's appropriate information is e receiving health care er. In the resident's medical record the transfer per paragraph (c)(1) aragraph (c)(1)(i)(A) of this resident need(s) that cannot in the resident in the receiving eed(s). On required by paragraph (c) must be made by-hysician when transfer or ary under paragraph (c) (1) etion; and in transfer or discharge is ragraph (c)(1)(i)(C) or (D) of ided to the receiving provider mum of the following: tion of the practitioner care of the resident. entative information including				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345164	B. WING _			C 08/22/2018
	ROVIDER OR SUPPLIER RIVER NURSING AND I	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932		00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION OF THE APPROVING ACTION OF THE APPROVING ACTION OF THE APPROVING ACT	OULD BE	(X5) COMPLETION DATE
F 622	copy of the resident's consistent with §483 any other documents a safe and effective to This REQUIREMEN' by: Based on record revinterviews, the facility documentation of crit discharge necessary and documentation to needs of the resident (Resident #2) review and discharge. The findings included Resident #2 was adready 2/28/2018 with diagn falls, altered mental swas discharged to an A wandering risk asswas scored as 10, wrisk for wandering. Her admission Minimassessment dated 3/2 cognition was moder exhibited wandering	propriate. Care plan goals; ary information, including a se discharge summary, (21(c)(2) as applicable, and ation, as applicable, to ensure transition of care. To is not met as evidenced riews and staff and family a failed provide Physician teria for facility-initiated for the resident's welfare, the facility could not meet the at for 1 of 3 residents to for admission, transfer defended to the facility on coses to include a history of status, and dementia. She nother facility on 5/11/2018. Ressment dated 2/28/2018 with 5 or below being not at the staff and she behaviors for 1 to 3 days of She was independent with	F 6	Chowan River Nursing and Reha acknowledges receipt of the State Deficiencies and proposes this PI Correction to the extent that the s of findings is factually correct and to maintain compliance with appli rules and provisions of quality of residents. The Plan of Correction submitted as a written allegation compliance. Chowan River Nursing and Rehal response to this Statement of Deficiencies nor doconstitute an admission that any deficiency is accurate. Further, CRiver Nursing and Rehabilitation the right to refute any of the deficient this Statement of Deficiencies Informal Dispute Resolution, form appeal procedure and/or any othe administrative or legal proceeding. The process that led to this deficient.	ement of an of summary I in order cable care of as is of billitation ficiencies the es it Chowan reserves iencies through all er g. ency	
	Her care plan, initiate problem of ineffective	ed on 3/7/2017 included a e coping: wandering related ent. Interventions included		(F622) was the facility failed to give reasonable and appropriate notice discharge for a discharge from the to another facility related to inabilimeet the needs of the resident.	e for e facility ity to	

Facility ID: 923018

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NAME OF PROVIDER OR SUPPLIER CHOWAN RIVER NURSING AND REHABILITATION CENTER EPERTON, N.C. 27832 FROM READ REPORT WAS TEMENT OF DEFICIENCES EPERTON, N.C. 27832 FROM REGULATORY OR I SCIDENTIFYING INFORMATION) FREERY TAG CHOWAN RIVER NURSING AND REHABILITATION CENTER TO PROVIDERS PLAN OF CORRECTION FREERY TAG PROVIDERS PLAN OF CORRECTION PREPRY TAG PROVIDERS PLAN OF SHORT PLAN OF SHO		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	· ,		ATE SURVEY OMPLETED	
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DENTON, NC 27932 Continued From page 3 redirect resident, allow resident to wander on unit, check daily to ensure resident has an alarm bracelet on and that it is functioning properly. Document episodes of wandering. A wandering risk assessment dated 3/9/2018 was scored as 10, a high risk of wandering.					13	341 PARADISE ROAD P O BOX 566		
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and felt it was exit seeking. The resident wore an alarm bracelet and her whereabouts were properly documented physician orders to show that the transfer is necessary for the			-					
alarm bracelet and her whereabouts were show that the transfer is necessary for the			•					
monitored. Her Legal Guardian (LG) was made resident□s welfare and that the facility is								

Facility ID: 923018

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			TE SURVEY MPLETED
		345164	B. WING			C
NAME OF D	ROVIDER OR SUPPLIER	343104	B: Willo _	STREET ADDRESS, CITY, STATE, ZIP COD		8/22/2018
NAME OF PI	ROVIDER OR SUPPLIER				E	
CHOWAN	RIVER NURSING AND I	REHABILITATION CENTER		1341 PARADISE ROAD P O BOX 566		
				EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 622	Continued From pag	e 4	F 6	22		
	seeking behaviors are The DON and LG has with a locked unit mattime. LG was agreed to that facility tomorn. A notice of transfer/d documented the date Reasons for discharge. It is necessary for needs cannot be me. The safety of incendangered due to the status of the resident The discharge notice as follows: "You have transfer/discharge to within 11 calendar date."	ischarge dated 6/1/2018 e of discharge as 5/11/2018. ge were listed as: or your welfare and your t in this facility; dividuals in this facility is ne clinical or behavioral		unable to meet the resident didentified areas of concern with immediately addressed by the Administrator during the audit on 8/30/18 100% in-service winvolved with the discharge princlude the Administrator, DO medical records, and social winitiated by the Administrator to 1. Any resident discharged facility will have: a. Reasonable and appropring for discharge b. A physician social wind discharge by the Administrator to see a proper for discharge continues the proper for discharge by the Administrator to show the facility cannot meet the needs	vith persons rocess, to N, finance, rork was to include: from the liate notice ation of rge is welfare hat the	
	conducted with Resident #2's let Resident #2 was adriterm, as she was not unsupervised by here visited Resident #2's DON and Administrated behaviors of wander stated he was unawabehaviors had gotter discharged until he was told she was told she was told she was told facility. He stated he home or find another	2 PM, an interview was dent #2's LG who stated he gal guardian. The LG stated nitted to the facility for long a safe to be at home self. The LG stated he erry often and spoke with the tor about Resident #2's ng and exit seeking. The LG are that the resident's a so bad that she had to be was called on 5/10/2018 and be discharged the next day. If there wasn't was told he could take her a facility of his choice. The wast in the afternoon when		resident 100% of residents discharging facilities will be reviewed by the Administrator weekly for 8 we monthly for 1 month, utilizing Discharge to Other Facility Autensure that all discharges are proper notice and have a phy supporting that the transfer we necessary for the resident supporting that the facility could not mee of the resident. Any areas of identified during the review we immediately addressed by the Administrator to include obtain order clarification by the phys providing additional staff train	ne eks, then the idit Tool to e given sician order as welfare and t the needs concern ill be e ning an ician and/or	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345164	B. WING		C 08/22/	/2040
NAME OF PE	ROVIDER OR SUPPLIER	0.0.01	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	00/22/	12016
				1341 PARADISE ROAD P O BOX 566		
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER		EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE C	(X5) COMPLETION DATE
F 622		e 5 and he did not have time to	F 62	The Administrator will present the		
	find another facility. Targue with the DON as if he had no choice have received a 30-da placement for Reside On 8/15/2018 at 3:15	The LG stated he did not and it was presented to him e. The LG stated he should ay notice to find another and #2. PM, a phone interview was		Findings of the Discharge Audit Tool Executive QI committee monthly for 3 months. The Executive QI committee meet monthly for 3 months and revie Discharge to Other Facility Audit Too determine trends and/or issues that r need further interventions put into pla	e will w the I to nay ace	
	employed at the facility discharged on 5/11/20 remembered Resider and made attempts to stated they were concexit the facility. The E transferred to another a locked unit because	locumented that in her note		and to determine the need for further frequency of monitoring. The administrator will be responsible the implementation of corrective actionclude all 100% of audits, in-service and monitoring related to the	for	
	facility when Resident	o was employed at the t #2 was discharged on ger employed at the facility for interview.				
	conducted with the pr	PM, an interview was esent DON who stated she w the guidelines when t to another facility.				
F 690 SS=D	unsuccessful. Bowel/Bladder Incont		F 69	00	9/	17/18
	§483.25(e) Incontiner §483.25(e)(1) The factoresident who is continuous					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		345164	B. WING _		08/22/2018
	ROVIDER OR SUPPLIER RIVER NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932	1 00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 690	Continued From pag	ge 6	F6	90	
	admission receives maintain continence	services and assistance to unless his or her clinical nes such that continence is			
	ensure that- (i) A resident who er indwelling catheter is resident's clinical co catheterization was (ii) A resident who e indwelling catheter c is assessed for rema as possible unless the demonstrates that c and (iii) A resident who is receives appropriate prevent urinary tract	on the resident's essment, the facility must the facility without an sonot catheterized unless the indition demonstrates that necessary; inters the facility with an or subsequently receives one loval of the catheter as soon the resident's clinical condition atheterization is necessary; is incontinent of bladder at treatment and services to infections and to restore			
	ensure that a reside receives appropriate restore as much nor possible. This REQUIREMEN by: Based on observati staff and resident in have a diagnosis for catheter, Physician catheter, how often	resident with fecal		Chowan River Nursing and Rel acknowledges receipt of the Sta Deficiencies and proposes this I Correction to the extent that the of findings is factually correct ar to maintain compliance with app	atement of Plan of summary and in order

PRINTED: 09/24/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
			A. BOILDIN		C	
		345164	B. WING _		I -	2/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		L/ L 0 10
				1341 PARADISE ROAD P O BOX 566		
CHOWAN	RIVER NURSING AN	D REHABILITATION CENTER		EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 690	Continued From p	age 7	F 6	590		
		nt #3) observed for indwelling		rules and provisions of qual residents. The Plan of Corr submitted as a written allega	ections is	
	compliance.	ation of				
	7/10/2017 with dia muscle weakness hypertension, card There was no diag catheter. Hospital discharge included a diagnos discharge orders,	admitted to the facility on gnoses to include hip fracture, congestive heart failure, diomyopathy, and pacemaker. gnosis for the indwelling e orders dated 7/10/2018 sis of retention of urine, but and discharge summary did not		Chowan River Nursing and response to this Statement does not denote agreement Statement of Deficiencies not constitute an admission that deficiency is accurate. Furt River Nursing and Rehabilit the right to refute any of the on this Statement of Deficie Informal Dispute Resolution	of Deficiencies with the or does it t any her, Chowan ation reserves deficiencies ncies through , formal	
	include any mention catheter.	on of an indwelling urinary		appeal procedure and/or an administrative or legal proce		
	Resident #3's Care plan, initiated 7/10/2018, included an altered pattern of bladder elimination with indwelling catheter. Interventions included change catheter per physician orders.			The process that led to this (F690) was the facility failed diagnosis for an indwelling catheter, Physician orders the catheter, how often to cl	I to have a urinary for the use of	
	Resident's #3's his	ess note dated 7/11/2018 for story and physical revealed her r was present and draining		catheter, or an assessment the catheter for 1 of 3 reside #3) observed for indwelling	ents (resident catheters.	
	Data Set (MDS) at revealed her cogn extensive to total a activities of daily li urinary catheter fo	deview of Resident #3's admission Minimum lata Set (MDS) assessment dated 7/17/2018 evealed her cognition was intact, she required extensive to total assistance from staff for ctivities of daily living, and she had an indwelling rinary catheter for bladder elimination. No iagnosis was listed for the indwelling catheter.		On 8/16/18 resident #3 was the physician to review the oreed for an indwelling cather order to attempt voiding trail indwelling catheter was remassigned hall nurse with no retention noted. On 8/16/18 100% Audit of a	continued eter with new I. Resident #3 oved by the further urinary	
	did not included or	or July 2018 and August 2018 rders to change the indwelling sis for the catheter, or a plan		with Foley catheters was co the Minimum Data Set Nurs include resident #3 to ensur	mpleted by e (MDS) to	

Facility ID: 923018

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345164	B. WING		C
NAME OF D	ROVIDER OR SUPPLIER	0.0.0.		STREET ADDRESS, CITY, STATE, ZIP CODE	08/22/2018
NAME OF FI	NOVIDER OR SUFFLIER				
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER		1341 PARADISE ROAD P O BOX 566	
				EDENTON, NC 27932	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 690	Continued From page	÷ 8	F 690		
	for removal of the cat	heter		indwelling urinary catheters were	
				complete to include appropriate diagn	osis.
	On 8/15/2018 at 12:3	9 PM an interview was		size of catheter and parameters for	33.3,
		ent #3, who stated she had		changing the urinary catheters presen	t in
		she couldn't stand or bear		chart and MAR. All identified areas of	
		cause of her fractured hip.		concern were immediately addressed	
		taff currently got her up with		the MDS nurse and the Assistant Dire	· .
	a lift to her chair. The	Resident did not say she		of Nursing (ADON) during the audit wi	th
	had a history of urinal	ry retention.		notification of physician for order	
				clarifications and correction of MAR/T	AR.
		1 PM, an interview was			
		ng assistant (NA) #1. The		On 8/16/18 100% audit of all care	
		3 was alert and oriented.		plan/care guides for resident with	
		ive Resident #3 peri care/		indwelling catheters to include residen	
		d emptied her catheter bag		was completed by the MDS to ensure	
	at the end of her shift			residents with indwelling catheters we	
	O= 0/40/2040 =+ 40.4	C ANA an interview was		care planned for use of catheter to inc	
		6 AM, an interview was		supporting diagnosis, size of catheter,	
		#1. The Nurse stated she display a catheter, but there was		how often to change catheter. All area concern were immediately addressed	
	no documentation on			the MDS nurse to include updating ca	-
		d (MAR) that the catheter		plan/care guide.	
		nift, because no orders had		plantoure guide.	
		atheter. The Nurse stated		On 8/16/18 100% Audit of Medication	
		e catheter are written and		Administration Record (MAR) x30 day	s of
	·	e MAR to check the catheter		residents with indwelling catheters to	
		nent. The nurse did not		include resident #3 was completed by	the
	_	nsible for obtaining orders		MDS to ensure documentation was	
	for the urinary cathete	-		complete and indwelling urinary cathe	ters
	-			had been changed per physician orde	rs.
	On 8/20/2018 at 4:13	PM, an interview was		Any areas of concern identified during	the
		or of Nursing (DON). The		audit were immediately addressed by	
	DON stated it was he			DON by conducting an assessment of	
		ing nurse would get the		resident to include the indwelling urina	ary
	_	elling catheter, as well as		catheter for any abnormalities,	
		or discontinue the indwelling		signs/symptoms of UTI, changing of	
	_	sician. The DON stated		urinary catheter per physician, notifica	tion
		the incident to see where		of the physician, and/or providing	
	the breakdown occurr	ed.		additional staff training.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345164	B. WING			C
NAME OF D	ROVIDER OR SUPPLIER	343104	5: 11::10	STREET ADDRESS, CITY, STATE, ZIP C		08/22/2018
TVAIVIL OF T	NOVIDER OR OUT FIER			1341 PARADISE ROAD P O BOX 566		
CHOWAN	RIVER NURSING AND	REHABILITATION CENTER		EDENTON, NC 27932		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 690	conducted with the stated he did not re	06 PM, a phone interview was Physician. The Physician ecall the specifics of her	F 6	On 09/14/18 100% in-servinurses will be completed by of Nursing (DON) in regard	y the Director Is to Physician	
	information would I The Physician state no orders for when catheter. The Phys to do a trial of remo had worked with a enough to be on a most of the time the	on her arrival, but that be in his history and physical. ed he was unaware there were to change the resident's sician stated he generally tried bying the catheter after therapy resident too get them stable bed pan. The Physician stated hospital would send orders t that was overlooked for this		Orders for Indwelling Urina include: 1. Any resident admitted urinary catheter must have order for use of catheter to a. Supporting medical dia of catheter such as urinary related to BPH, bladder car neurogenic bladder, retract stage 3-4 sacral wound b. Size of catheter to incluballoon c. Parameters for when to catheter d. Block the date for the richange per physician order e. Notifying the physician orders that do not contain a diagnosis, size and instruct to change indwelling urinar 2. Care Plan/Care guide updated for Indwelling Cath include diagnosis for use, since and parameters for changing In-service will be completed All newly hired nurses will be by the Staff Facilitator/DON orientation to ensure all ordindwelling urinary catheters to include: 1. Any resident admitted urinary catheter must have	with indwelling a physician sinclude: agnosis for use retention neer, table pain, ude size of the character of the MAR in the clarify any appropriate tions on when by catheters must be neter use to size of catheter, and catheter. In a catheter to a complete with indwelling appropriate tions on when by catheters must be neter use to size of catheter, and catheter.	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	I` '		(X3) DATE SURVI COMPLETED	
		345164	B. WING			C 08/22/20	140
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, S	STATE ZIP CODE	06/22/20	J 10
				1341 PARADISE ROAD P			
CHOWAN	RIVER NURSING AND R	EHABILITATION CENTER		EDENTON, NC 27932	0 20X 000		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)	E COM	(X5) IPLETION DATE
F 690	Continued From page	÷ 10	F	order for use of ca a. Supporting m of catheter such a related to BPH, bi neurogenic bladd stage 3-4 sacral w b. Size of cathete balloon c. Parameters f catheter d. Block the dat change per physic e. Notifying the orders that do not diagnosis, size ar to change indwell 2. Care Plan/Ca updated for Indwe include diagnosis and parameters for 10% of residents will be reviewed b for 8 weeks, then utilizing a Foley A all orders for indw have supporting of catheter, paramet catheters, orders to the MAR, and of completed on the indwelling urinary the physician orde concern identified immediately addres	er, retractable pain, wound eter to include size of for when to change the for the next catheter cian order on the MAI physician to clarify and the contain appropriate and instruction is on whiting urinary catheters are guide must be celling Catheter use to for use, size of catheter changing catheters with indwelling catheters are transcribed consumentation is MAR when the catheter is changed ers. Any areas of a during the review will essed by the DON to an ode clarification, ending physician eresident and /or	r R ny en ter, · ers ekly at rs e of ctly	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
		345164	B. WING			C 08/22/2018	
	ROVIDER OR SUPPLIER RIVER NURSING AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932			
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F 690	Continued From page	: 11	F 69	The DON will present the Findi Foley Audit Tool to the Executive committee monthly for 3 month Executive QI committee will me for 3 months and review the Formool to determine trends and/or that may need further intervent into place and to determine the further frequency of monitoring. The administrator and the DON responsible for the implemental corrective actions to include all audits, in-services, and monito to the plan of correction.	ve QI ns. The eet monthly bley Audit or issues tions put e need for l. N will be ation of I 100% of		